STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 18,413
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department of Prevention, Assistance, Transition, and Health Access (PATH) establishing the amount of the spend-down that he must incur in order to be eligible for the Medicaid program. The issue is whether the petitioner should get "working-disabled" disregards to determine his countable income in the spend-down program.

FINDINGS OF FACT

1. The petitioner has been a Medicaid recipient for some time under "working disabled" rules. This means that he has a total income under 250 percent of the poverty line and is allowed disregards for all of his earned income and $500 of his Social Security benefits when figuring his countable income. That income is then compared to the income test used for all persons in Medicaid.

2. In January of 2003, the petitioner received a small cost of living increase in his Social Security benefits.

Based on this income, PATH recalculated his eligibility for Medicaid and determined that he was $7.00 over the limit for Medicaid eligibility under the "working disabled" category. The petitioner does not dispute this determination.

3. On March 7, 2003, PATH notified the petitioner that his Medicaid would be terminated after March 31, 2003 based on this increase in income. He was also notified that pursuant to Medicaid rules, he could re-establish his Medicaid eligibility if he incurred a certain amount of medical expenses in the next six months, known as a "spend-down". PATH notified the petitioner that his spend-down amount would be $4,459.50.[1]

4. In calculating his spend-down amount, PATH used a methodology to find his countable income which is employed in the traditional Medicaid category, not in the "working-disabled" category. PATH counted all of the petitioner's Social Security income of $1,293 minus a $20 standard

[1] PATH originally notified the petitioner that the amount would be $4,107.30. On April 3, 2003, the petitioner was notified that the original calculation had been in error because he had received deductions for the payment of Medicare premiums and should not have because he is not a Medicare recipient.

unearned income deduction. It also counted his earned income minus certain income deductions used for persons in the traditional Medicaid program, to reach a countable total of $236.25 for his earned income. The countable unearned and earned income combined resulted in a total countable monthly income of $1,509.25. That amount was compared to the monthly protected income limit (PIL) for an individual receiving Medicaid of $766 per month. The monthly amount by which his countable income exceeded the PIL was determined to be $743.25. That amount was multiplied by the six-month accounting period to obtain the spend-down figure of $4,459.50.

5. The petitioner disputes the method of calculation used by PATH. He says that he should receive the “working disabled”, not the traditional Medicaid disregards when his spend-down is calculated. If this methodology is employed, $500 of the petitioner’s unearned Social Security income would be disregarded in addition to the $20 standard deduction for a countable unearned income of $773. None of his earned income would be counted so $773 would be the total countable income. The amount by which $773 exceeds the PIL of $766 per month is $7. That amount multiplied by the 6-

month period is $42 which is the amount of spend-down he feels he should have to meet.

ORDER[2]

The matter is remanded to allow DCF to consider whether it will change its rule prohibiting working deductions in the spend-down program and to notify the petitioner of its decision.

REASONS

Pursuant to authority given to it under Section 4733 of the United States Balanced Budget Act of 1997, 42 USC § 1396a(a)(10)(A)(ii)(XIII), and the Vermont Omnibus Appropriation Act of 1999, Public Law 62, Section 121 (H.544) PATH (now DCF) opted to cover a new category of individuals in the Medicaid program known as “working disabled” persons

[2] The recommendation in this matter was originally provided to the Board in August of 2003. That recommendation was that PATH should be reversed because the regulation that it originally relied on, M402, contained no provision prohibiting the use of earnings and SSDI disregard for spenddown purposes. The matter was never heard by the Board because the parties requested several continuances. In February of 2003, PATH asked for reconsideration, submitting an entirely new argument and the matter was remanded to the hearing officer at that time to consider the new arguments and any response that might be submitted by the petitioner. A new recommendation was issued in favor of PATH which was approved by the Board on July 16, 2004. After the petitioner informed the Board that he had not received timely notice of the Board’s July meeting, the matter was reopened and scheduled for hearing again. After a hearing before the Board on October 1, 2004, the matter was remanded for further argument by the petitioner who said he had misunderstood the Board’s authority to hear legal argument at this stage. Following new legal memoranda submitted by the parties, a new recommendation was issued.

and duly promulgated regulations governing that new category in January of 2000.

At the time of PATH's original decision in this case, the regulation covering this category was found at M200(16). On August 3, 2003, during the pendency of this appeal, PATH reorganized its regulations and that coverage category is now found at M200.24 and reads as follows[3]:

> The following individuals are eligible for SSI-related Medicaid as categorically needy.
>
> . . .
>
> (b) Working people with disabilities – Individuals with disabilities who are working and otherwise eligible for SSI-related Medicaid except that their net income:
>
> (i) is below 250 percent of the federal poverty level associated with the applicable family size; and
>
> (ii) does not exceed either the Medicaid protected income level for one or the SSI/AABD payment level for two, whichever is higher, after disregarding the earnings and up to $500 of social security disability insurance benefits

[3] The new regulations will be used in this recommendation as they came into effect during the petitioner's six month certification period, contain no new provisions (only a reorganization of old ones), and the petitioner has continued to receive benefits pending this appeal far past the period of their enactment.

> (SSDI) of the individual working with disabilities.
>
> **Earnings and SSDI shall not be disregarded for applicants with spenddown requirements.**[4] (Emphasis supplied.)

The petitioner who has been determined to be disabled by the Social Security Administration and who is also working was a beneficiary of this new optional coverage. He received Medicaid because he was able to disregard all of his earned income and $500 of his Social Security which brought him under the Medicaid limit ("protected income level" or "PIL") for his household size.

When the petitioner's Social Security income increased in 2003, the petitioner was notified that he would no longer be eligible under the above category because after the deductions allowed in the regulation he was still over the limit (the "PIL"). The petitioner was notified that he could be enrolled in the "medically needy" program which allows him to become eligible for Medicaid by "spending down" his income to the PIL level by incurring medical expenses.

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[4] The final requirement in bold was not contained in the original M200(16) which was superseded by this regulation. However, that same requirement was found in another regulation in effect at that time, M240, which provided that "[I]n determining eligibility for an assistance group with a working disabled member, earnings and SSDI shall not be disregarded when the group must meet a spenddown requirement." That regulation was also superseded on August 1, 2003 but the quoted restriction was folded into the current cited regulation above.

DCF's regulations allow persons whose income is over the PIL to become eligible for Medicaid as part of the "medically needy" program. The methodology employed to determine eligibility provides for the disregard of income based on incurring certain medical expenses as set forth in the following regulations:

> The following spenddown . . . provisions apply to individuals requesting SSI-related . . . Medicaid. . . They are calculated using an accounting period of . . . six months.
>
> When a Medicaid group's total countable income or resources exceed the applicable income or resource standard for eligibility after allocations are made, and exclusions and disregards are applied, a person requesting Medicaid may use spenddown provisions to attain financial eligibility. . .
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> M400
>
> Individuals who pass all nonfinancial eligibility tests may qualify for Medicaid coverage by spending down the income or resources in excess of applicable maximums. . .
>
> Spending down is the process by which a Medicaid group incurs allowable expenses to be deducted from its income or spends resources to meet financial eligibility requirements. . .
>
> M410
>
> An income spenddown is the amount of qualifying medical expenses a Medicaid group must incur to reduce its income to the maximum applicable to their Medicaid coverage category. The department determines that a person requesting Medicaid with excess income has passed the income test upon proof that the Medicaid group has paid or incurred medical expenses . . . at least equal

> to the difference between its countable income and the applicable income maximum for the accounting period.
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> M412

The above regulations governing the medically needy "spend-down" program contain no special income disregards for working persons. The regulation at M200.24 specifically prohibits using the disregards from the categorical "working disabled" program in the "medically needy" spenddown program. It is clear that DCF's regulations do not allow the income disregards used in the working disabled program to be used in calculating eligibility for the "spend-down" program. DCF has followed this regulation in calculating the petitioner's continued eligibility for Medicaid. The result for the petitioner is that even though he is only $7 over the PIL for the working disabled program, without the disregards the petitioner must incur over $4,000 in the spend-down program in order to be eligible for Medicaid.

The argument made by the petitioner is that DCF's rules conflict with both the federal and state laws regarding eligibility for "working disabled programs" and should be declared invalid. The federal law establishing the program was adopted in 1997 and provides as follows:

> A state plan for medical assistance must provide for making medical assistance at the option of the state, to

> any group or groups in individuals described in Section 1396d(a)(1) of this title, to any reasonable categories of such individuals who are not individuals described in clause (i) of this subparagraph but who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under Section 1396d(q)(2)(B) of this title would be considered to be receiving supplemental security income (subject notwithstanding section 1396o of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine.)
>
> 42 USC § 1396a(a)(10)(A)(ii)(XIII)

This statute allows states at their option to cover persons who are working so long as their net income is no more than 250 percent of the federal poverty level. (This is a much higher level than traditional disabled Medicaid recipients whose eligibility is tied to SSI eligibility standards which are less than half this amount.) The methodology used to determine the eligibility of persons in this new category is largely left to the states. In January of 2001, Vermont opted to adopt this coverage category through the following language in an appropriations bill:

> (h) Of the above special funds, $46,000 shall be used to extend Medicaid eligibility to disabled workers in families whose income is less than 250 percent of the federal poverty level and who would be considered to be receiving supplemental security income (SSI) except for earnings in excess of SSI income limits that are

> attributable to savings from earnings. In addition, up to $500 per month of the disabled worker's Social Security disability insurance payments shall be disregarded in the Medicaid eligibility determination. The commissioner shall have the authority to establish program premiums and other cost-sharing charges by rules for such coverage. These funds shall be matched with available federal funds.
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> Omnibus Appropriation, Public Act 62, § 121 (H.554), 1999

The petitioner argues that this enabling legislation requires a state opting to enact this category to carry over the methodology into all of its other Medicaid programs, including its medically needy program. However, the petitioner points to nothing in the federal statute which would cause him or anyone else reading it to reach that conclusion. He further argues that it was the intent of the Vermont legislature not just to create a new category for the working disabled but to extend the methodology described in the appropriation to all Medicaid programs, including the medically needy spend-down program.

The petitioner urges his interpretation largely on the basis of information he obtained from the Centers for Medicare and Medicaid Services (CMS) web site involving a June 2003 report which he claims shows that many other states have adopted working disabled disregards in their spend-downs

calculations.[5] Although a review of that report does not indicate that this is the case, the report itself concerns a different Medicaid federal "work-ticket" option not adopted by Vermont. A more recent report from the same web site concerning the program actually used by Vermont and many other states[6] did not contain any information indicating that any state has adopted special working disabled deductions in the spend-down program. Even if the report had shown this to be true, it would not indicate that DCF is required by federal statute and regulation to adopt work disregards in its medically needy program.

DCF maintains that the above language in the federal statute allows the state to adopt a new category of Medicaid coverage for disabled working persons but does not require it or even allow it to adopt new disregards in its other programs, including the medically needy "spend-down" program. DCF argues, relying on a decision of the federal court of appeals in DeJesus v. Perales, 770 F.2d 316, 326 (2nd. Cir. 1985), that the spend-down calculation is not part of the basic standard to be employed in Medicaid eligibility but rather a method by which an applicant who does "not meet the

[5] See http://www.gao.gov/news.items/d03587.pdf

standard can nonetheless bring its excess income down to the level required for inclusion in the Medicaid program." Thus, the term "Medicaid eligibility determination" in the above legislative directive means only Medicaid eligibility under a categorical program, and not the methodology used to find persons eligible as medically needy who do not meet the regular categorical standards.

DCF further relies on language in the code of federal regulations at 42 C.F.R. § 435.811(a) which requires that "to determine the eligibility of medically needy individuals, a Medicaid agency must use a single income standard" as a prohibition against employing special deductions for working individuals who are seeking to meet requirements through a spend-down which it does not use for other SSI-related individuals. Furthermore, DCF argues that the code of federal regulations specifically requires that "the agency must deduct the following amounts from income to determine the individual's countable income [for medically needy programs] . . . [f]or aged blind or disabled individuals in States covering all SSI recipients, the agency must deduct amounts that would be deducted in determining eligibility

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[6] "The Effectiveness of Medicaid Buy-In Programs in Promoting the Employment of People with Disabilities." June 2004, Appendix A.

under SSI." 42 C.F.R. § 435.831. These regulations, in DCF's view, require that SSI disabled working persons be subject to the same deductions as all others who do not meet categorical requirements when they try to meet Medicaid standards through the spend-down.

DCF is correct that at the time Vermont opted into the program in 1999, the federal agency, the Center for Medicare and Medicaid Services of the Department of Health and Human Services (CMS), had regulations in place which interpreted the federal Medicaid statute as requiring that all persons applying as medically needy be subjected to the same uniform standard. See "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources" May 11, 2001, at www.cms.hhs.gov/medicaid/eligibility/elig0501.pdf CMS reinterpreted that statute by amending 42 CFR 1007 on January 11, 2001 to allow for more liberal eligibility methodologies. See 66 Fed. Reg. 2316 (2001). CMS has made it clear that it would now allow working disabled deductions in the medically needy program to receive federal financial participation. See "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources." Supra, paragraph C1. The corollary to that assertion is that it

would not have allowed such a scheme prior to January 11, 2001 and, indeed, never required such a scheme either now or then. Thus, DCF's argument that the federal statute did not require the adoption of such methodologies in the medically needed program is well-supported. That being the case, it must also be true that the legislature's direction in the 1999 appropriations bill to DCF (then PATH) to expand the Medicaid program must have meant an expansion within the parameters of federal financial participation then extant, which in 1999 would not have included the medically needy program.

It must be concluded that DCF's regulation prohibiting the use of working disabled deductions in the medically needy program is not in conflict with either federal or state law. It does appear, however, that under 42 USC 1396a(c)(2), DCF may now have the authority, if it wishes to exercise it, to apply those deductions to its medically needy program. Since DCF has largely relied on its perceived inability under federal law to apply working disabled deductions in the spend-down program to defend its decision, it is now incumbent upon DCF to review this ruling of CMS and to determine whether it wishes to exercise the option of expanding those disregards. This case is remanded to DCF to

review CMS' ruling and to make a decision as to whether or not it wishes to now grant those deductions to the petitioner and other working disabled persons. The petitioner should understand that if DCF decides not to exercise its authority to extend the deductions, the Board is in no position to override that policy decision as such a decision is a discretionary one for the agency and the legislature.

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